CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 1 (3-Page Format)

44080

This page may be completed by potential vaccine recipient

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

1. Today's Date (M M / D D / Y Y Y Y) ☐☐ / ☐☐ / ☐☐☐☐

2. GENDER ○ Male ○ Female

2a. FEMALES: Was your last menstrual period normal and on time? ○ Yes ○ No ○ Unsure

2b. Are you currently breastfeeding? ○ Yes ○ No

3. Could someone you LIVE WITH or YOU be pregnant? ○ Yes ○ No ○ Unsure

4. Did you ever receive smallpox vaccine? ○ Yes ○ No ○ Unsure

4a. IF YES: Were you vaccinated within the last 10 years? ○ Yes ○ No ○ Unsure

4b. IF UNSURE: Birth Year ☐☐☐☐ First Year in Military (if applicable) ☐☐☐☐

5. Have you ever had a serious problem after smallpox or other vaccination? (Describe below) ○ Yes ○ No ○ Unsure

6. Do you currently have an illness with fever? ○ Yes ○ No ○ Unsure

7. Are you allergic to any of these products: tetracycline, streptomycin, polymyxin B, neomycin, latex? ○ Yes ○ No ○ Unsure

Before vaccinating against smallpox, we want to know if you or your household close contacts have any of several medical conditions. Please answer the following questions to the best of your knowledge.

	Myself	Close Contact
8. Do you OR someone you currently live with NOW HAVE any of the following skin problems: Psoriasis (scaly skin rash), Burns (other than mild sunburn), Impetigo (skin infection), Uncontrolled Acne, Shingles (herpes zoster), Chickenpox, Darier's disease or Other skin condition with multiple breaks in skin (describe below)?	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
9. Do you OR someone you currently live with NOW HAVE or RECENTLY HAD a problem or take(s) medication that affects the immune system? For example: have or take medication for HIV, AIDS, leukemia, lymphoma, or chronic liver problem; have or take medication for Crohn's disease, lupus, arthritis, or other immune disease; have had radiation or X-ray treatment (not routine X-rays) within the last 3 months; have EVER had a bone-marrow or organ transplant (or take medication for that); or have another problem that requires steroids, prednisone or a cancer drug for treatment.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10. Have you OR someone you currently live with EVER HAD Eczema or Atopic Dermatitis? (Usually this skin condition involves an itchy, red, scaly rash that lasts more than 2 weeks. It often comes and goes.) IF YES or UNSURE: for either you or your close contact, Answer 10a-10e	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10a. A doctor has made the diagnosis of eczema or atopic dermatitis.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10b. There have been itchy rashes that have lasted more than 2 weeks.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10c. At least once, there is a history of an itchy rash in the folds of the arms or legs.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10d. There is a history of eczema and food allergy during childhood.	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure
10e. A doctor has made the diagnosis of asthma or hayfever (including first-degree relatives).	○ Yes ○ No ○ Unsure	○ Yes ○ No ○ Unsure

11. Do you have other questions or have other concerns you would like to discuss? ○ Yes ○ No

NOTE: If you think you might have one of the many risk factors for HIV infection, we can arrange for HIV testing before vaccination.
FOR FEMALES: If you think you might be pregnant, you should get a pregnancy test before vaccination. Please tell us.

Explain "other," "unsure," or additional concerns (may use additional page)

Last Name

First Name MI

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPART./SER

44080

CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 2 (3-Page Format)

This page to be completed by health care provider

Vaccinee number (optional for QA)

1. Provider Assessment Date (MM/DD/YYYY)

__ __ / __ __ / __ __ __ __

2. Reason for Vaccination (Indicate One):

○ Pre-outbreak: disease prevention

○ Post-outbreak: not exposed to virus

○ Post-outbreak: exposed to virus

○ Other reason (Describe)

3. Vaccine Risk Factors based on page 1 review and additional interview if needed (Check all that apply):

	Self	Close contact	
No risk factors	☐	☐	
Pregnancy	☐	☐	
Immune supression	☐	☐	
Skin condition	☐	☐	Refer to skin condition assessment tool for clinical evaluation guidance
Relevant allergy	☐		
Unsure/other risk	☐	☐	(Describe)

4. Comment on any concerns about contraindications, need to defer, need to consult, and/or relevent diagnosis

5. Provider Decision and Plan (Check all that apply):

☐ Vaccinate: Primary (e.g. birth year >1972, military entry >1984)

☐ Vaccinate: Revaccination

☐ Medically immune: vaccinated within approp interval (MI)

☐ Vaccination deferred: Pending consult or lab test

☐ Vaccination deferred: Temporary contraindication (MT)

☐ Vaccination contraindicated unless exposed (MP)

☐ Vaccination not given (other reason specify below):

6. Provider Action, Check all that apply:

☐ Reason for vaccination decision explained

☐ Patient understands information given

☐ Lab test requested

☐ Consult request written/sent_____

☐ Follow up appointment planned (Date: _____)

☐ Other reason (specify below):

Provider Plan and Action Additional Comments (e.g., length of temporary deferrals, what labs/consults requested)

Provider Signature and Printed Name/Stamp:

Last Name

First Name MI

Social Security Number

__ __ __ - __ __ - __ __ __ __

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
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CHRONOLOGICAL RECORD OF MEDICAL CARE

Smallpox Vaccination Initial Note Page 3 (3-Page Format)

This page may be completed by health care provider or vaccine administrator

VACCINE ADMINISTRATION

Immunization Date (M M / D D / Y Y Y Y)

Date Briefed (M M / D D / Y Y Y Y)

Vaccination Adminstration Site Name

Vital Signs (if indicated) Temp . Resp Pulse BP /

Immunized; number of jabs:

Location: ○ Left Arm ○ Right Arm ○ Other Location (Describe)

Default Lot # is 4020071, Mfr is WAL (Wyeth Ayerst Laboratories)
IF Lot # and/or Mfr are different, specify below:

Lot # Mfr

For QA use: local vial serial #

Check all that apply:

- ☐ Information sheet given to recipient
- ☐ Recipient understands information given about post-vaccination reaction and site care
- ☐ Vaccination site observation: no break in skin
- ☐ Vaccination site observation: trace blood
- ☐ Vaccination site observation: petechia(e)
- ☐ Vaccination site observation: frank bleeding
- ☐ Bandages provided
- ☐ Reasons for follow-up clinic visit described
- ☐ Vaccination repeated

Additional Comments (e.g., reason for vaccination repeat)

Vaccine administered by: (Signature and Printed Name/Stamp)

Please assure that all actions taken and deferrals are updated into your service's electronic Immunization Tracking System (ITS) as soon as possible.

Last Name

First Name MI

Social Security Number - -

Patient's Identification (May use mechanical imprint)

RECORDS MAINTAINED AT:
RANK/GRADE
SEX
DATE OF BIRTH
SPONSOR NAME
(or Sponsor SSN)
RELATIONSHIP TO SPONSOR
(or FMP)
ORGANIZATION
STATUS
DEPART./SER